Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLEN ORTHOTICS & PROSTHETICS
2502 WEST OHIO AVENUE
MIDLAND TX 79701

Respondent Name

Texas Mutual Insurance Company

Carrier's Austin Representative

Box Number 54

MFDR Tracking Number

M4-10-4844-01

MFDR Date Received

July 27, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Upon investigation I discovered that effective January 1, 2010 the Medicare Pricing, Date Analysis and Code (PDAC) inactivated L1800 and cross-walked it to A4466. Because of that, on March 19, 2010 the appropriate correction was made and a claim for A4466 and L2795 was submitted."

Amount in Dispute: $ 112.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has nothing further to add in its response to this dispute beyond what was previously communicated through its EOBs."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2010	A4466	$112.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 612 – No payment is made as Medicare uses another code for reporting and/or payment of this service.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 793 – Reduction due to PPO contract. PPO contract was applied by Focus/Aetna Workers Comp Access LLC
   - CAC-214 – Workers' Compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment
   - 891 – No additional payment after reconsideration

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor submit documentation to support the billing of HCPCS Code A4466?
3. Is HCPCS code A4466 valued by Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule and/or valued by the Texas Medicaid Fee schedule?
4. Did the requestor submit documentation to support the fair and reasonable reimbursement for HCPCS code A4466?

Findings

1. The insurance carrier reduced disputed services with reason codes "45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement" and "793 – Reduction due to PPO contract. PPO contract was applied by Focus/Aetna Workers Comp Access LLC." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on January 11, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as a documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment pursuant to the applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for DME HCPCS code A4466 defined as "Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each." Review of the documentation submitted for review supports the billing of HCPCS code A4466, therefore the disputed charge will therefore be reviewed pursuant to 28 Texas Administrative Code §134.203.
3. Per 28 Texas Administrative Code §134.203 (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   Review of the CGS Medicare website (http://www.cgsmedicare.com/jc/index.html) to determine the DMEPOS payment for A4466 does not document a MPFS reimbursement rate for HCPCS code A4466. Review of the Texas Medicaid fee schedule to determine the DMEPOS payment for A4466 does not document a fee schedule amount for HCPCS code A4466, as a result, the disputed charge will be reviewed pursuant to 28 Texas Administrative Code §134.203 (f).

4. Per 28 Texas Administrative Code §134.203 (f) "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Per 28 Texas Administrative Code §133.307(c) (2) (G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
   - The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

   The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 31, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.